FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026914

Facility Name: Concord Extended Care

Address: 9401 South Ridgeland (Number) Oak Lawn (City) 60453 (Zip Code)

County: Cook

Telephone Number: (708) 449-9090 **Fax #** (708) 449-7070

IDPA ID Number: 362833027001

Date of Initial License for Current Owners: 00/00/67

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Edward N. Slack, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	134	Skilled (SNF)	134	48,910	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	134	TOTALS	134	48,910	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,808	360	3,913	7,081	8
9	SNF/PED					9
10	ICF	28,393	8,643		37,036	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,201	9,003	3,913	44,117	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.20%

D. How many bed-hold days during this year were paid by Public Aid?
144 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1962

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 3,913

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	195,562	27,418	13,357	236,337		236,337	(8,322)	228,015			1
2	Food Purchase		171,719		171,719	(22,283)	149,436	2,739	152,174			2
3	Housekeeping	200,229	47,165		247,394		247,394	(3,604)	243,790			3
4	Laundry	71,976	17,107		89,083		89,083	(35)	89,048			4
5	Heat and Other Utilities			101,687	101,687		101,687	1,156	102,843			5
6	Maintenance	46,326		78,503	124,829		124,829	1,708	126,537			6
7	Other (specify):*							1,947	1,947			7
8	**TOTAL General Services**	514,093	263,409	193,547	971,049	(22,283)	948,766	(4,412)	944,354			8
	B. Health Care and Programs											
9	Medical Director			5,076	5,076		5,076		5,076			9
10	Nursing and Medical Records	1,655,817	60,080	119,646	1,835,543		1,835,543	(10,526)	1,825,017			10
10a	Therapy	56,598		3,839	60,437		60,437	392	60,829			10a
11	Activities	76,024	3,678	3,420	83,122		83,122	21	83,143			11
12	Social Services	83,633		10,784	94,417		94,417	998	95,415			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							9,925	9,925			15
16	**TOTAL Health Care and Programs**	1,872,072	63,758	142,765	2,078,595		2,078,595	810	2,079,405			16
	C. General Administration											
17	Administrative	21,647		222,154	243,801		243,801	6,290	250,091			17
18	Directors Fees											18
19	Professional Services			294,801	294,801	(9,890)	284,911	(189,936)	94,975			19
20	Dues, Fees, Subscriptions & Promotions			39,667	39,667		39,667	(22,827)	16,840			20
21	Clerical & General Office Expenses	62,189	12,801	240,524	315,514		315,514	(100,208)	215,306			21
22	Employee Benefits & Payroll Taxes			375,579	375,579	22,283	397,862	(27,249)	370,613			22
23	Inservice Training & Education			17	17		17		17			23
24	Travel and Seminar			2,683	2,683		2,683	956	3,639			24
25	Other Admin. Staff Transportation			5,824	5,824		5,824	(5,484)	340			25
26	Insurance-Prop.Liab.Malpractice			169,911	169,911		169,911	956	170,867			26
27	Other (specify):*							23,933	23,933			27
28	**TOTAL General Administration**	83,836	12,801	1,351,160	1,447,797	12,393	1,460,190	(313,569)	1,146,621			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,470,001	339,968	1,687,472	4,497,441	(9,890)	4,487,551	(317,172)	4,170,379			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Concord Extended Care #0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			78,301	78,301		78,301	69,901	148,202			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(7,782)	(7,782)		(7,782)	262,876	255,094			32
33	Real Estate Taxes					9,890	9,890	139,931	149,821			33
34	Rent-Facility & Grounds			509,028	509,028		509,028	(506,186)	2,842			34
35	Rent-Equipment & Vehicles			4,422	4,422		4,422	1,422	5,844			35
36	Other (specify):*			973	973		973	32,939	33,912			36
37	**TOTAL Ownership**			584,942	584,942	9,890	594,832	883	595,715			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		168,436	202,929	371,365		371,365	(5,432)	365,933			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			73,365	73,365		73,365		73,365			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		168,436	276,294	444,730		444,730	(5,432)	439,298			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,470,001	508,404	2,548,708	5,527,113		5,527,113	(321,720)	5,205,393			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(30)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	13,416	30		9
10	Interest and Other Investment Income	(16,439)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(346)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(192,000)	21		24
25	Fund Raising, Advertising and Promotional	(4,518)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,317)	20		28
29	Other-Attach Schedule	(42,161)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (243,395)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(78,325)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (78,325)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (321,720)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Concord Extended Care

ID# 0026914

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty	$ (17)	21	1
2	Patient Clothing	(74)	10	2
3	Collection Expense	(2,102)	21	3
4	Bank Charges	(5,627)	21	4
5	Theft Loss	(20)	21	5
6	IL Council Long Term Care Cope Payments	(1,704)	20	6
7	VA Expense	(15,306)	10	7
8	Oxygen Expense - VA	(137)	10	8
9	Contributions - Charity	(86)	20	9
10	Penalties	(3,965)	20	10
11	Professional Fees - Bldg. Co.	(8,075)	19	11
12	Bank Charges - Bldg. Co.	(116)	21	12
13	Amortization - Bldg Co.	(2,245)	36	13
14	Licenses & Fees - Bldg. Co.	(200)	20	14
15	Daiwa Fee	(1,879)	19	15
16	Capitalized R&M	(608)	06	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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98				98
99				99
100				100
101	**Total**	(42,161)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary			38		(2,331)	(4,449)		(1,580)				(8,322)	1
2	Food Purchase	(376)		(68)			3,183						2,739	2
3	Housekeeping					724			(4,328)				(3,604)	3
4	Laundry								(35)				(35)	4
5	Heat and Other Utilities			1,156									1,156	5
6	Maintenance	(608)		1,206	(1,502)	2,652	8		(48)				1,708	6
7	Other (specify):*				1,011	732	204						1,947	7
8	**TOTAL General Services**	(984)		2,332	(491)	1,777	(1,054)		(5,991)				(4,412)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(15,517)		152	521	8,375			(4,057)				(10,526)	10
10a	Therapy				1	391							392	10a
11	Activities			21									21	11
12	Social Services				881	117							998	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				8,844	1,081							9,925	15
16	**TOTAL Health Care and Programs**	(15,517)		173	10,247	9,964			(4,057)				810	16
	C. General Administration													
17	Administrative				(2,281)	8,425	146						6,290	17
18	Directors Fees													18
19	Professional Services	(9,954)	8,075	(188,105)			48						(189,936)	19
20	Fees, Subscriptions & Promotions	(11,790)	200	(11,250)			13						(22,827)	20
21	Clerical & General Office Expenses	(199,882)	116	12,853	2,808	83,586	311						(100,208)	21
22	Employee Benefits & Payroll Taxes				(26,353)			(486)	(410)				(27,249)	22
23	Inservice Training & Education													23
24	Travel and Seminar			556			400						956	24
25	Other Admin. Staff Transportation			(5,484)									(5,484)	25
26	Insurance-Prop.Liab.Malpractice			956									956	26
27	Other (specify):*				12,564	11,369							23,933	27
28	**TOTAL General Administration**	(221,626)	8,391	(190,474)	(13,262)	103,380	918	(486)	(410)				(313,569)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(238,127)	8,391	(187,969)	(3,506)	115,121	(136)	(486)	(10,459)				(317,172)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Concord Extended Care # 0026914 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	13,416	50,331	6,154									69,901	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(16,439)	267,200	12,112			3						262,876	32
33	Real Estate Taxes		138,214	1,717									139,931	33
34	Rent-Facility & Grounds		(509,028)	2,842									(506,186)	34
35	Rent-Equipment & Vehicles			1,344			78						1,422	35
36	Other (specify):*	(2,245)	35,184										32,939	36
37	**TOTAL Ownership**	(5,268)	(18,099)	24,169			81						883	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(2,808)		(2,624)				(5,432)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(2,808)		(2,624)				(5,432)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(243,395)	(9,708)	(163,800)	(3,506)	115,121	(2,863)	(486)	(13,083)				(321,720)	45

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule		See Attached Schedule		See Attached Schedule		
				Concord Health Care Properties		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	$ 509,028	Concord Health Care Properties, LLC		$	$ (509,028)	1
2	V	32	Interest Income	857				(857)	2
3	V	19	Professional Fees				8,075	8,075	3
4	V	21	Bank Charges				116	116	4
5	V	30	Depreciation				50,331	50,331	5
6	V	36	Amortization				2,245	2,245	6
7	V	33	Real Estate Tax Expense				138,214	138,214	7
8	V	20	Licenses & Fees				200	200	8
9	V	32	Interest Expense				268,057	268,057	9
10	V	36	MIP Expense				32,939	32,939	10
11	V								11
12	V								12
13	V								13
14	Total			$ 509,885			$ 500,177	$ * (9,708)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 38	$ 38	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	1,156	1,156	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	1,206	1,206	17
18	V	10	Nursing	23	Care Centers, Inc.	100.00%	175	152	18
19	V	11	Activities		Care Centers, Inc.	100.00%	21	21	19
20	V	19	Professional Fees	195,831	Care Centers, Inc.	100.00%	7,726	(188,105)	20
21	V	20	Dues and Subscriptions	12,136	Care Centers, Inc.	100.00%	886	(11,250)	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	12,853	12,853	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	556	556	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	956	956	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	6,154	6,154	25
26	V	32	Interest		Care Centers, Inc.	100.00%	12,112	12,112	26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,717	1,717	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	2,842	2,842	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,344	1,344	29
30	V	25	Bus Reimbursement	5,484	Care Centers, Inc.	100.00%		(5,484)	30
31	V	02	Food	68	Care Centers, Inc.	100.00%		(68)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 213,542			$ 49,742	$ * (163,800)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$ 9,238	Care Centers, Inc.	100.00%	$ 7,736	$ (1,502)	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,011	1,011	16
17	V	10	Nursing Salary	60,838	Care Centers, Inc.	100.00%	61,359	521	17
18	V	10a	Rehab Salary	437	Care Centers, Inc.	100.00%	438	1	18
19	V	11	Activity Salary	348	Care Centers, Inc.	100.00%	348		19
20	V	12	Social Service Salary	8,532	Care Centers, Inc.	100.00%	9,413	881	20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	8,844	8,844	21
22	V	17	Administration Salary	77,569	Care Centers, Inc.	100.00%	75,288	(2,281)	22
23	V	21	Office Salary	19,214	Care Centers, Inc.	100.00%	22,022	2,808	23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	12,564	12,564	24
25	V	22	Employee Benefits	26,353	Care Centers, Inc.	100.00%		(26,353)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 202,529			$ 199,023	$ * (3,506)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$ 4,854	Care Centers, Inc.	100.00%	$ 2,523	$ (2,331)	15
16	V	03	Housekeeping Salary		Care Centers, Inc.	100.00%	724	724	16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	2,652	2,652	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	732	732	18
19	V	10	Nursing Salary		Care Centers, Inc.	100.00%	8,375	8,375	19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%	391	391	20
21	V	12	Social Services Salary		Care Centers, Inc.	100.00%	117	117	21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,081	1,081	22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	8,425	8,425	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	83,586	83,586	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	11,369	11,369	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,854			$ 119,975	$ * 115,121	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 6,822	Care Centers, Inc. - Health Systems Division	100.00%	$ 808	$ (6,014)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	3,183	3,183	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	8	8	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	146	146	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	48	48	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	13	13	20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	311	311	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	400	400	22
23	V	32	Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	3	3	23
24	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	78	78	24
25	V	39	Ancillary Enteral Supplies	5,265	Care Centers, Inc. - Health Systems Division	100.00%	2,457	(2,808)	25
26	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	1,565	1,565	26
27	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	204	204	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 12,087			$ 9,224	$ * (2,863)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 115,254	$ 115,254	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	115,740	CCS EMPLOYEE BENEFIT GROUP	100.00%		(115,740)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 115,740			$ 115,254	$ * (486)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ 12,003	XCEL MEDICAL SUPPLY, LLC	100.00%	$ 10,423	$ (1,580)	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	32,884	XCEL MEDICAL SUPPLY, LLC	100.00%	28,556	(4,328)	17
18	V	04	LAUNDRY	267	XCEL MEDICAL SUPPLY, LLC	100.00%	232	(35)	18
19	V	06	REPAIRS & MAINTENANCE	363	XCEL MEDICAL SUPPLY, LLC	100.00%	315	(48)	19
20	V	10	NURSING	30,826	XCEL MEDICAL SUPPLY, LLC	100.00%	26,768	(4,057)	20
21	V	10A	THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS	3,117	XCEL MEDICAL SUPPLY, LLC	100.00%	2,706	(410)	24
25	V	39	ANCILLARY	19,931	XCEL MEDICAL SUPPLY, LLC	100.00%	17,308	(2,624)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 99,391			$ 86,309	$ * (13,083)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Noah Wolff	Owner	Administrative	16.67%	See Attached	10.00	25.00%	Mgmt Fee	$ 72,292	17-03	1
2	Eric Rothner	Owner	Administrative	33.33%	See Attached	0.94	1.70%	Mgmt Fee	72,292	17-03	2
3	Mark Steinberg	Relative	Administrative	0.00%	See Attached	3.00	5.94%	CCI Alloc.	1,169	17-07	3
4	Adam Vales	Relative	Clerical	0.00%	See Attached	0.59	1.48%	CCS VEBA Alloc	461	22-03	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 146,214		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,764,895	42	$ 1,527	$	44,117	$ 38	1
2	05	Utilities	Patient Days	1,764,895	42	46,229		44,117	1,156	2
3	06	Maintenance	Patient Days	1,764,895	42	48,251		44,117	1,206	3
4	10	Nursing	Patient Days	1,764,895	42	7,018		44,117	175	4
5	11	Activities	Patient Days	1,764,895	42	838		44,117	21	5
6	19	Professional Fees	Patient Days	1,764,895	42	309,074		44,117	7,726	6
7	20	Dues and Subscriptions	Patient Days	1,764,895	42	35,428		44,117	886	7
8	21	Office & Clerical	Patient Days	1,764,895	42	523,091		44,117	12,853	8
9	24	Travel and Seminar	Patient Days	1,764,895	42	22,233		44,117	556	9
10	26	Insurance	Patient Days	1,764,895	42	38,230		44,117	956	10
11	30	Depreciation	Patient Days	1,764,895	42	246,194		44,117	6,154	11
12	32	Interest	Patient Days	1,764,895	42	484,531		44,117	12,112	12
13	33	Real Estate Taxes	Patient Days	1,764,895	42	68,681		44,117	1,717	13
14	34	Rent - Building	Patient Days	1,764,895	42	113,677		44,117	2,842	14
15	35	Rent - Equipment & Auto	Patient Days	1,764,895	42	53,777		44,117	1,344	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,998,780	$		$ 49,742	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			213,393	213,393		7,736	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			26,918			1,011	2
3	10	Nursing Salary	Direct Cost			976,718	976,718		61,359	3
4	10a	Rehab Salary	Direct Cost			103,898	103,898		438	4
5	11	Activity Salary	Direct Cost			10,902	10,902		348	5
6	12	Social Service Salary	Direct Cost			306,863	306,863		9,413	6
7	15	Emp. Ben. - Healthcare	Direct Cost			174,348			8,844	7
8	17	Administration Salary	Direct Cost			1,191,200	1,191,200		75,288	8
9	21	Office Salary	Direct Cost			698,886	698,886		22,022	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			238,998			12,564	10
11	22	Employee Benefits								11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,942,124	$ 3,501,860		$ 199,023	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,764,895	42	100,923	100,923	44,117	2,523	1
2	03	Housekeeping Salary	Patient Days	1,764,895	42	28,979	28,979	44,117	724	2
3	06	Maintenance Salary	Patient Days	1,764,895	42	106,088	106,088	44,117	2,652	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,764,895	42	29,264		44,117	732	4
5	10	Nursing Salary	Patient Days	1,764,895	42	335,028	335,028	44,117	8,375	5
6	10a	Rehab Salary	Patient Days	1,764,895	42	15,649	15,649	44,117	391	6
7	12	Social Services Salary	Patient Days	1,764,895	42	4,661	4,661	44,117	117	7
8	15	Emp. Ben. - Healthcare	Patient Days	1,764,895	42	43,235		44,117	1,081	8
9	17	Administration Salary	Patient Days	1,764,895	42	337,043	337,043	44,117	8,425	9
10	21	Office Salary	Patient Days	1,764,895	42	3,343,864	3,343,864	44,117	83,586	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,764,895	42	454,813		44,117	11,369	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,799,547	$ 4,272,235		$ 119,975	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,073,579		138,556		12,087	808	1
2	02	Food	Billable Income	2,073,579		852,614		12,087	3,183	2
3	06	Maintenance	Billable Income	2,073,579		1,311		12,087	8	3
4	17	Administration	Billable Income	2,073,579		25,000		12,087	146	4
5	19	Professional Fees	Billable Income	2,073,579		8,170		12,087	48	5
6	20	Dues & Subscriptions	Billable Income	2,073,579		2,312		12,087	13	6
7	21	Office & Clerical	Billable Income	2,073,579		53,285		12,087	311	7
8	24	Travel & Seminar	Billable Income	2,073,579		68,680		12,087	400	8
9	32	Interest Expense	Billable Income	2,073,579		571		12,087	3	9
10	35	Rent - Equipment & Auto	Billable Income	2,073,579		13,336		12,087	78	10
11	39	Ancillary Enteral Supplies	Billable Income	2,073,579		114,955		12,087	2,457	11
12	01	Dietary - Salary	Billable Income	2,073,579		268,554	268,554	12,087	1,565	12
13	07	Emp. Ben. - Gen. Serv.	Billable Income	2,073,579		34,942		12,087	204	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,582,287	$ 268,554		$ 9,224	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURA	DIRECT ALLOCATION			$	$		$ 115,254	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 115,254	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$ 10,423	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						28,556	3
4	04	LAUNDRY	Direct Allocation						232	4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						315	5
6	10	NURSING	Direct Allocation						26,768	6
7	10A	THERAPY	Direct Allocation							7
8	12	SOCIAL SERVICE	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation						2,706	10
11	39	ANCILLARY	Direct Allocation						17,308	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 86,309	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD		X	Mortgage			$	$ 4,114,321			$ 268,057	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Daiwa Loan		X	Working Capital							3,778	6
7												7
8	See Supplemental Schedule										12,115	8
9	TOTAL Facility Related						$	$ 4,114,321			$ 283,950	9
	B. Non-Facility Related*											
10												10
11	Interest Income										(16,439)	11
12	Interest Income - Bldg. Co.										(857)	12
13	See Supplemental Schedule										(11,560)	13
14	TOTAL Non-Facility Related						$	$			$ (28,856)	14
15	TOTALS (line 9+line14)						$	$ 4,114,321			$ 255,094	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 32,939 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Alloc. - Care Centers, Inc.		X				$	$			$ 12,112	8
9	Alloc. - Care Centers, Inc. -											9
10	Health Systems Division		X								3	10
11												11
12												12
13												13
14	TOTAL Working Capital										12,115	14
	B. Non-Facility Related*											
15	Prior Year Interest		X				$	$			$ (11,560)	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										(11,560)	20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Concord Extended Care # 0026914 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$ 152,910	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 145,128	2
3. Under or (over) accrual (line 2 minus line 1).	$ (7,782)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 147,713	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$ 9,890	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 149,821	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	125,208	8
1999	133,766	9
2000	141,972	10
2001	145,632	11
2002	143,411	12

Line 2 = $143,411 + Alloc. From Care Centers, Inc. $1,717

2003 Real Estate Tax Accrual = 2002 Tax Bill $143,411 * 1.03

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Concord Extended Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026914

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-05-302-003-0000	Long Term Care Property	$ 143,410.78	$ 143,410.78
2.	See Attached	Home Office Allocation	$ 68,681.49	$ 1,716.83
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 212,092.27	$ 145,127.61

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Concord Extended Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026914

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,133 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: Finance Costs, Closing Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	56,110	1962	$ 27,417	1
2	Alloc. 2201 Main, LLC			12,708	2
3	TOTALS	56,110		$ 40,125	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1974	1,435		20	-		1,435	9
10	Various			1976	4,663		20	-		4,663	10
11	Various			1977	2,336		20	-		2,336	11
12	Various			1978	765		20	-		765	12
13	Various			1980	33,145		20	-		33,145	13
14	Various			1982	2,378		20	-		2,292	14
15	Various			1983	45,375		20	1,815	1,815	36,341	15
16	Various			1984	21,344		20	853	853	15,714	16
17	Various			1985	14,833		20	742	742	13,355	17
18	Various			1986	16,300		20	815	815	13,855	18
19	Various			1988	41,219		20	1,662	1,662	26,107	19
20	Various			1989	3,324		20	166	166	2,377	20
21	Various			1990	8,400		20	420	420	5,495	21
22	Various			1991	34,006		20	1,702	1,702	21,762	22
23	Various			1992	8,695		20	435	435	4,938	23
24	Various			1993	11,679		20	585	585	6,249	24
25	Various			1994	29,410		20	1,472	1,472	14,056	25
26	Various			1995	118,494		20	5,927	5,927	49,253	26
27	Various			1996	68,945		20	3,449	3,449	24,938	27
28	Various			1997	54,013		20	2,701	2,701	17,422	28
29	Various			1998	158,651		20	7,933	7,933	43,513	29
30	Various			1999	40,891		20	2,045	2,045	9,961	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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48									48
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		1,945,046	50,331		57,012	6,681	1,122,827	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		48,070	1,608		1,608		1,711	68
69	Financial Statement Depreciation			14,463			(14,463)		69
70	TOTAL (lines 4 thru 69)		$ 2,713,417	$ 66,402		$ 91,342	$ 24,940	$ 1,474,510	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,713,417	$ 66,402		$ 91,342	$ 24,940	$ 1,474,510	1
2	New Roof	2000	58,000		20	2,900	2,900	10,392	2
3	Sink Project	2000	891		20	45	45	160	3
4	Control Head	2000	523		20	26	26	89	4
5	Tuckpointing	2000	14,500		20	725	725	2,477	5
6	Fuel Tank	2000	1,133		20	57	57	189	6
7	Painting	2000	7,000		20	350	350	1,167	7
8	Painting	2000	3,350		20	168	168	559	8
9	Closet Doors	2000	2,250		20	113	113	376	9
10	Closet Doors	2000	1,500		20	75	75	250	10
11	Closet Doors	2000	1,250		20	63	63	209	11
12	Painting	2000	9,000		20	450	450	1,463	12
13	Cubicle Curtains	2000	2,688		20	134	134	403	13
14	Door Frame	2000	1,200		20	60	60	180	14
15	Closets/Doors	2000	6,717		20	336	336	1,008	15
16	Door Closure	2000	3,250		20	163	163	488	16
17	Closets/Doors	2000	560		20	28	28	84	17
18	Compressor	2000	2,437		20	122	122	366	18
19	Switch System	2000	4,882		20	244	244	732	19
20	Door	2000	628		20	31	31	94	20
21	Fire Alarm Cabine	2000	1,090		20	55	55	164	21
22	Hood System	2000	685		20	34	34	103	22
23	Adt Security Service	2001	4,051		20	203	203	557	23
24	Voice Mail System	2001	997		20	50	50	133	24
25	Frig Ac	2001	660		20	33	33	88	25
26	Landscape	2001	959		20	48	48	124	26
27	Frig A/C	2001	(565)		20	(28)	(28)	(619)	27
28	Elevator Repairs	2001	717		20	36	36	87	28
29	Plumbing	2001	500		20	25	25	60	29
30	Fire Panel	2001	5,600		20	280	280	677	30
31	Plumbing	2001	500		20	25	25	56	31
32	Plumbing	2001	500		20	25	25	54	32
33	Plumbing	2001	1,916		20	49	49	145	33
34	TOTAL (lines 1 thru 33)		$ 2,852,786	$ 66,402		$ 98,267	$ 31,865	$ 1,496,825	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,852,786	$ 66,402		$ 98,267	$ 31,865	$ 1,496,825	1
2	Air Conditioner	2001	585		20	15	15	44	2
3	Plumbing	2001	632		20	16	16	47	3
4	Plumbing	2002	500		20	50	50	100	4
5	Plumbing	2002	500		20	50	50	100	5
6	Elevator Repair	2002	875		20	88	88	168	6
7	Blinds	2002	940		20	94	94	180	7
8	Tybony	2002	2,141		20	214	214	393	8
9	Painting	2002	1,437		20	144	144	263	9
10	Sewer Clean Outside	2002	1,500		20	150	150	275	10
11	Fire Service	2002	1,737		20	248	248	455	11
12	Fire Service	2002	1,000		20	143	143	262	12
13	Plumbing	2002	500		20	50	50	88	13
14	Plumbing	2002	500		20	50	50	79	14
15	Smoke Alarm	2002	502		20	72	72	114	15
16	Window Treatments	2002	2,448		20	245	245	367	16
17	Paint	2002	743		20	149	149	223	17
18	Walk In Cooler	2002	1,094		20	156	156	208	18
19	Telephone Equipment	2002	501		20	50	50	63	19
20	Heat Exchanger	2002	680		20	136	136	159	20
21	Huac	2003	2,838		20	47	47	47	21
22	Fix Bathroom Plumbing	2003	2,515		20	21	21	21	22
23	Locks	2003	3,798		20	348	348	348	23
24	Repair Hot Water Heater	2003	813		20	61	61	61	24
25	Door Key Pads	2003	875		20	66	66	66	25
26	Front Door	2003	4,800		20	240	240	240	26
27	Plumbing	2003	2,515		20	105	105	105	27
28	Steel Door	2003	950		20	40	40	40	28
29	Glass Door	2003	2,200		20	73	73	73	29
30	Exhaust System	2003	2,600		20	65	65	65	30
31	Code Alert - Alarm	2003	608		20	35	35	35	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,896,113	$ 66,402		$ 101,488	$ 35,086	$ 1,501,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,896,113	$ 66,402		$ 101,488	$ 35,086	$ 1,501,514	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,896,113	$ 66,402		$ 101,488	$ 35,086	$ 1,501,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,896,113	$ 66,402		$ 101,488	$ 35,086	$ 1,501,514	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,896,113	$ 66,402		$ 101,488	$ 35,086	$ 1,501,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,896,113	$ 66,402		$ 101,488	$ 35,086	$ 1,501,514	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
17									17
18									18
19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,896,113	$ 66,402		$ 101,488	$ 35,086	$ 1,501,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,896,113	$ 66,402		$ 101,488	$ 35,086	$ 1,501,514	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,896,113	$ 66,402		$ 101,488	$ 35,086	$ 1,501,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,896,113	$ 66,402		$ 101,488	$ 35,086	$ 1,501,514	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,896,113	$ 66,402		$ 101,488	$ 35,086	$ 1,501,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,896,113	$ 66,402		$ 101,488	$ 35,086	$ 1,501,514	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,896,113	$ 66,402		$ 101,488	$ 35,086	$ 1,501,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 2,896,113	$ 66,402		$ 101,488	$ 35,086	$ 1,501,514	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,896,113	$ 66,402		$ 101,488	$ 35,086	$ 1,501,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 2,896,113	$ 66,402		$ 101,488	$ 35,086	$ 1,501,514	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,896,113	$ 66,402		$ 101,488	$ 35,086	$ 1,501,514	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1962	1962	$ 339,532	$		$	$	$	4
5			1987	1987	1,493,264	50,331		57,012	6,681	1,122,827	5
6			1962	1962	112,250						6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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54									54
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,945,046	$ 50,331		$ 57,012	$ 6,681	$ 1,122,827	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	2201 Main, LLC		2002		$ 17,513	$ 438		$ 438	$	$ 474	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2201 Main, LLC			2002	16,215	811		811		878	9
10	2201 Main, LLC			2003	14,342	359		359		359	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 48,070	$ 1,608		$ 1,608	$	$ 1,711	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 391,415	$ 54,828	$ 36,834	$ (17,994)	10	$ 221,072	71
72	Current Year Purchases	22,844	11,725	7,912	(3,813)	10	7,912	72
73	Fully Depreciated Assets	381,866				10	381,866	73
74								74
75	TOTALS	$ 796,125	$ 66,553	$ 44,746	$ (21,807)		$ 610,850	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		ALLOC. -CCI		$ 18,210	$ 1,831	$ 1,968	$ 137	5	$ 14,330	76
77										77
78										78
79										79
80	TOTALS			$ 18,210	$ 1,831	$ 1,968	$ 137		$ 14,330	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,750,573	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 134,786	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 148,202	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 13,416	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,126,694	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Alloc. CCI				2,842			5
6								6
7	TOTAL				$ 2,842 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 5,844 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 87,098	$		$ 87,098	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			15,739			15,739	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			100,092			100,092	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				84,865		84,865	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						83,571		83,571	13
14	TOTAL			$		$ 202,929	$ 168,436		$ 371,365	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 8,596	$ 9,044	1
2	Cash-Patient Deposits	29,149	29,149	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	639,325	639,325	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	136,455	184,968	6
7	Other Prepaid Expenses	18,096	18,096	7
8	Accounts Receivable (owners or related parties)	14,350	14,350	8
9	Other(specify): See Attached Schedule	404,743	664,689	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,250,714	$ 1,559,621	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		27,417	13
14	Buildings, at Historical Cost		2,069,821	14
15	Leasehold Improvements, at Historical Cost	835,939	835,939	15
16	Equipment, at Historical Cost	847,114	847,114	16
17	Accumulated Depreciation (book methods)	(1,051,308)	(2,180,275)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	10,125	10,125	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(10,125)	(10,125)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		75,219	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 631,745	$ 1,675,235	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,882,459	$ 3,234,856	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 862,229	$ 870,627	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,989	28,989	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	169,932	169,932	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,667	9,667	31
32	Accrued Real Estate Taxes(Sch.IX-B)		147,713	32
33	Accrued Interest Payable		22,217	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(2,000)	(2,000)	35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,068,817	$ 1,247,145	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,114,321	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,114,321	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,068,817	$ 5,361,466	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 813,642	$ (2,126,610)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,882,459	$ 3,234,856	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,037,730	1	
2	Restatements (describe):		2	
3	PA Vent Income	26,074	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,063,804	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(250,162)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (250,162)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 813,642	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,021,967	1
2	Discounts and Allowances for all Levels	(964,526)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,057,441	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	936,539	6
7	Oxygen	18,915	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 955,454	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	30	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	99,927	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,468	19
20	Radiology and X-Ray	2,150	20
21	Other Medical Services	134,025	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 247,600	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,439	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,439	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	17	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,276,951	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	971,049	31
32	Health Care	2,078,595	32
33	General Administration	1,447,797	33
	B. Capital Expense		
34	Ownership	584,942	34
	C. Ancillary Expense		
35	Special Cost Centers	371,365	35
36	Provider Participation Fee	73,365	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,527,113	40
41	**Income before Income Taxes (line 30 minus line 40)****	(250,162)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (250,162)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,341	1,481	$ 35,690	$ 24.10	1
2	Assistant Director of Nursing	345	345	8,886	25.76	2
3	Registered Nurses	8,766	9,708	216,873	22.34	3
4	Licensed Practical Nurses	23,541	25,673	533,052	20.76	4
5	Nurse Aides & Orderlies	76,690	81,936	831,141	10.14	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,858	5,416	56,598	10.45	8
9	Activity Director	1,263	1,441	17,318	12.02	9
10	Activity Assistants	6,900	7,620	58,706	7.70	10
11	Social Service Workers	6,022	5,116	83,633	16.35	11
12	Dietician					12
13	Food Service Supervisor	2,356	2,598	41,768	16.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,409	18,579	153,794	8.28	15
16	Dishwashers					16
17	Maintenance Workers	1,468	1,598	46,326	28.99	17
18	Housekeepers	22,646	25,052	200,229	7.99	18
19	Laundry	6,914	7,696	71,976	9.35	19
20	Administrator	535	553	21,647	39.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,912	6,941	62,189	8.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,498	2,626	30,175	11.49	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	188,464	204,379	$ 2,470,001 *	$ 12.09	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	213	$ 8,503	01-03	35
36	Medical Director	Monthly	5,076	09-03	36
37	Medical Records Consultant	Monthly	4,343	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	750	10-03	39
40	Physical Therapy Consultant	54	1,350	10a-03	40
41	Occupational Therapy Consultant	46	2,052	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	64	3,072	11-03	44
45	Social Service Consultant	47	2,252	12-03	45
46	Other(specify)				46
47					47
48	CCI Allocation (See Attached)		75,010	Various	48
49	TOTAL (lines 35 - 48)	424	$ 102,408		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	959	$ 53,714	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	959	$ 53,714		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Scott Braun (1/1-3/24/03)	Administrator	0%	$
Stephen (3/24-5/16/03)	Administrator	0%	
Paula Martinez (5/19-10/7/03)	Administrator	0%	
Pamela Lee (10/8-12/31/03)	Administrator	0%	
Total Administrator Salary			21,647
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 21,647

B. Administrative - Other

Description	Amount
CCI - Administrative Payroll	$ 77,570
Management Fee - Eric Rothner	72,292
Management Fee - Noah Wolff	72,292
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 222,154

C. Professional Services

Vendor/Payee	Type	Amount
Care Centers, Inc.	Accounting	$ 15,000
FR&R	Accounting	23,470
Care Centers, Inc.	Legal	12,136
See Attached Schedule	Legal	58,188
Care Centers, Inc.	Bookkeeping	27,132
Alpha Data	Data Processing	399
Care Centers, Inc.	Data Processing	5,445
ADP	Data Processing	6,488
Care Centers, Inc.	Home Office Expense	111,720
Care Centers, Inc.	Ancillary Admin. Expense	15,960
TEG	Utility Consultant	675
See Supplemetal Schedule		18,188
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 294,801

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,208
Unemployment Compensation Insurance	20,309
FICA Taxes	180,076
Employee Health Insurance	59,851
Employee Meals	22,283
Illinois Municipal Retirement Fund (IMRF)*	
Employee Welfare	5,818
Pension Expense	836
Employee Physical	3,232
TOTAL (agree to Schedule V, line 22, col.8)	$ 370,613

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,340
Advertising: Employee Recruitment	4,320
Health Care Worker Background Check (Indicate # of checks performed 46)	551
Advertising and Promotion	4,518
Dues and Subscriptions	4,931
Licenses and Fees	3,799
Yellow Page Advertising	1,317
Alloc. - Care Centers, Inc.	886
See Supplemental Schedule	13
Less: Public Relations Expense	( )
Non-allowable advertising	(4,518)
Yellow page advertising	(1,317)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,840

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,683
Alloc. - Care Centers, Inc.	556
See Supplemental Schedule	400
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,639

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council Long Term Care $3,208**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,312** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **73,365**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **22,283** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **30**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.